Pharmaceutical Reimbursement Comparison Report

Indexing of Texas Workers' Compensation Pharmaceutical Reimbursement and Comparison to Other Healthcare Markets

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October 22, 2009

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EXECUTIVE SUMMARY

Milliman was engaged by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to evaluate pharmaceutical reimbursement levels under the Texas workers' compensation system and compare them to rates paid in other markets such as commercial and Medicare.

TDI-DWC is required by Texas Labor Code §413.011 to adopt reimbursement methodologies that result in effective cost containment and fair and reasonable reimbursement for services and treatments provided in the Texas workers' compensation system. The purpose of this report is to assist TDI-DWC in developing a market-based standard and understanding current reimbursement levels in the system. Milliman has not been asked to recommend a specific fee level; however we have been asked to assist in providing guidance on the benchmark to be used to define future payment levels.

The current Maximum Allowable Reimbursement (MAR) for Texas workers' compensation pharmaceutical claims is based on the lesser of Usual and Customary charges (U&C), negotiated fees, and a formula based on AWP. The MAR formula includes reimbursement of 109% and 125% of AWP for brand name and generic drugs, respectively, plus a $4.00 dispensing fee. To benchmark and analyze the MAR, TDI-DWC provided us with a dataset of Texas workers' compensation pharmaceutical claims for 2007 and 2008. Based on that dataset and the adjustments described in detail in this report, we estimate that reimbursement for brand name drugs averaged 96% of Average Wholesale Price (AWP), plus dispensing fees, while reimbursement for generic drugs averaged 88% of AWP, plus dispensing fees. We note that the average actual reimbursement levels are significantly less than the AWP indices in the MAR fee guideline. This implies that carriers are either utilizing a U&C amount below the fee level or are negotiating lower reimbursement levels.

The resulting pharmaceutical reimbursement for the Texas workers' compensation system is significantly above that seen in other markets. In the retail pharmacy setting of commercial, Medicaid, and Medicare, we typically see reimbursement of 83% to 87% of AWP, plus dispensing fees for brand name drugs and less than 45% of AWP for generic drugs, plus dispensing fees, after adjusting for Maximum Allowable Cost (MAC) provisions.

This report was prepared for TDI-DWC. While we understand that it may be distributed to third parties, we do not intend to benefit third parties. Any distribution of this report must be in its entirety.

The accuracy of our analysis depends on the accuracy of the data provided to us. While we have reviewed this data for reasonableness, we have not audited the data. We have also relied on Medi-Span and RED BOOK for various statistics related to drug pricing and therapeutic class coding. The drug pricing analysis and comparisons of the actual experience data were derived using the historical AWP as published in Medi-Span's Master Drug Data Base (MDDB). In our comparisons to other markets, we have relied on both publicly available and proprietary data.

INTRODUCTION

Milliman was engaged by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to evaluate pharmaceutical reimbursement levels under the Texas workers' compensation system and compare them to rates paid in other markets such as commercial and Medicare.

TDI-DWC is required by Texas Labor Code §413.011 to adopt reimbursement methodologies that result in effective cost containment and fair and reasonable reimbursement for services and treatments provided in the Texas workers' compensation system. The purpose of this report is to assist TDI-DWC in developing a market-based standard and understanding current reimbursement levels in the system.

Per §134.503 of TDI–DWC Rules, the current reimbursement methodology for pharmaceutical claims is as follows:

(a) The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of:

(1) The provider's usual and customary charge for the same or similar service;

(2) The fees established by the following formulas based on average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g., RED BOOK, First Data Bank Services) in effect on the day the prescription drug is dispensed.

A. Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR

B. Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR

C. A compounding fee of $15 per compound shall be added for compound drugs; or

(3) A negotiated or contract amount

TDI-DWC provided us with a dataset of pharmaceutical claims for 2007 and 2008. It contained about 2.9 million claims for those years, with approximately $276 million in paid claims. For each claim in the data set, we attached the AWP as a benchmark amount. This process is described in more detail in the Methodology section.

We calculated the resulting reimbursement as a percentage of AWP separately for generic and brand name drugs. Additional summaries of results were created by year, carrier, data submitter, and therapeutic class. These will be supplied in a separate document as excel files.

We compared the results to typical reimbursement levels in other markets, including commercial, Medicare, and Medicaid as well as to workers' compensation fee schedules in other states. Our data sources include public and proprietary data sources, described in detail in the Comparison to Other Healthcare Markets section.

RESULTS OF INDEXING TEXAS WORKERS' COMPENSATION PHARMACEUTICAL REIMBURSEMENT TO STANDARD BENCHMARKS

For the two-year period, average reimbursement for Texas workers' compensation pharmaceutical claims was approximately:

Brand name drugs: 98% of AWP, inclusive of dispensing fees

Generic drugs: 94% of AWP, inclusive of dispensing fees

The percentages above are equal to Total Paid Claims divided by Total AWP. We did not have data to specifically identify dispensing fees but these are typically included in the paid amounts. Following, in Table 1, are the results by year assuming a $4.00 per prescription dispensing fee as included in the MAR reimbursement formula.

Table 1

Results By Year Compared to MAR Formula

Source/Year	2007	2008	2007 & 2008	TDI-DWC MAR Formula
Brand Name				
Percentage of AWP	96%	96%	96%	109%
Dispensing Fees	$4.00	$4.00	$4.00	$4.00
Generic				
Percentage of AWP	91%	85%	88%	125%
Dispensing Fees	$4.00	$4.00	$4.00	$4.00

We note that the average reimbursement levels are significantly less than the MAR formula in the fee guideline. This implies that carriers either are utilizing a U&C amount below the fee level or are negotiating lower reimbursement levels.

AWP is, at this time, the most common benchmark used in defining pharmaceutical reimbursement, and is therefore very useful in comparing fee levels. Other potential benchmarks include Federal Upper Limit (FUL) pricing, often used in Medicaid programs, and Wholesale Acquisition Costs (WAC). The use of WAC is discussed in more detail in a later section.

METHODOLOGY FOR INDEXING TEXAS WORKERS' COMPENSATION PHARMACEUTICAL REIMBURSEMENT TO STANDARD BENCHMARKS

This section describes the process used to index the TDI-DWC data to a standard benchmark. It includes a description of resources used in the evaluation and adjustments made to the data Milliman received.

MEDI-SPAN

To evaluate the Texas workers' compensation reimbursement against standard benchmarks, we first attached historical AWP, based on date of fill, as published in Medi-Span's Master Drug Data Base (MDDB) to each claim. In addition to using Medi-Span's MDDB file to capture the AWP, we used it to identify each claim as a brand name or generic drug. The claims that were not included in the Medi-Span MDDB have been excluded from this analysis. There were a total of 92,487 claims which did not match (3.2% of the total).

RED BOOK

To evaluate and analyze the distribution of pharmaceutical prescriptions by therapeutic classification group we coded each claim with a therapeutic class indicator from RED BOOK's coding system. The claims data and benchmarked MedStat data were coded with the therapeutic subclasses as defined by RED BOOK in order to compare the distribution by therapeutic class to a commercial distribution. The subclasses fall into 102 therapeutic subclasses as defined by the RED BOOK's classification system.

ADDITIONAL DATA ADJUSTMENTS

The accurate reporting of drug quantities is critical in assigning an appropriate AWP amount. In our review of the data, we determined that there were various issues with respect to the reporting of quantities. In developing the results, we applied adjustments, described in this section, to address seemingly incorrect quantities.

First, we identified a significant portion of prescriptions appearing to show quantities of 100 times actual quantities (e.g., 12,000 quantity rather than 120 quantity per claim). We received an additional dataset from TDI-DWC that included Federal Employer Identification Numbers (FEINs) for the data submitters. Based on additional review, we concluded that all quantities reported by one particular submitter had been inappropriately multiplied by 100. We adjusted all the data identified with this submitter's FEIN for this apparent data inaccuracy.

In addition, we identified and excluded claims for which the paid amount was less than 10% of AWP. This exclusion represented about 0.8% of prescriptions.

We also determined that there were a number of claims with unreasonably large payment amounts compared to the calculated AWP. Based on a review of a sample of claims, this also appears to be primarily due to the misstatement of quantities, which affects the calculation of AWP. We therefore excluded claims for which the paid amount was more than two times AWP. This resulted in the exclusion of an additional 8.4% of claims, almost half of which came from a single submitter. In total, we excluded approximately 12.4% of claims and 7.1% of paid amounts, as listed in Table 2:

Table 2

Excluded Claims

Exclusion Type	% of Total Claim Count Excluded	% of Total Paid Dollars Excluded
Null Brand Name/Generic Category	3.2%	1.9%
Paid Amount Less than 10% of AWP	0.8%	0.6%
Outlier Submitter, Claims with Paid Amount Greater than 200% of AWP*	4.0%	3.9%
Other Submitters, Claims with Paid Amount Greater than 200% of AWP	4.4%	0.7%
Total Excluded	**12.4%**	**7.1%**

*Note that the 200% exclusion resulted in more than 68% of the outlier submitter's claims being excluded. However, because this submitter's claims represented only 5.9% (=4.0% / 68%) of the total claims, we believe their claims are unlikely to have materially changed our results if we had been able to include them all.

The reimbursement results shown in Table 1 in the prior section are after the adjustments described above. Had we defined different outlier cut-offs, results would vary from these estimates. In determining how to define excluded outliers, we attempted to balance the need to adjust for seemingly inaccurate data with the desire to rely on data as submitted. Due to the large number of claims, it would be prohibitive to review and adjust outlier issues on a claim-by-claim basis.

RESULTS OF INDEXING OTHER HEALTH CARE PHARMACEUTICAL REIMBURSEMENT TO A STANDARD BENCHMARK

Milliman was asked to benchmark the Texas workers' compensation pharmaceutical reimbursement levels against that in other markets. Here, we describe typical reimbursement formulas and reimbursement levels in other markets, based on published sources and internal proprietary data.

The most common formula for defining pharmacy reimbursement levels in all markets (e.g., commercial, Medicare, Medicaid, workers' compensation), is as a percentage of AWP (most commonly a discount) plus a dispensing fee per prescription. In addition, generic reimbursement is often restricted to a Maximum Allowable Cost (MAC).

Often an insurer or carrier will contract with a pharmacy benefit manager (PBM) in management of the prescription drug portion of a health benefit plan. The PBM's primary role is to provide administrative services in prescription claims processing, including pharmacy contracting and other claims processing services. Insurers and carriers work with PBMs to provide their members with access to discounted medications through an electronically run delivery system.

AWP is a published national average of list prices charged by wholesalers to pharmacies. AWP is sometimes referred to as a "sticker price" because it is not the actual price that large purchasers or PBMs normally pay. The AWP is the benchmark drug price level commonly used by pharmacy benefit plans for the contracting of brand name and generic prescription drug prices. AWP amounts are published by sources such as RED BOOK, Medi-Span, and First DataBank, and are derived from data reported by pharmaceutical manufacturers for brand name and generic drugs. At this time, neither the prescription drug industry nor governmental agencies require AWP to reflect actual sale prices. As a result, AWP should not be considered an accurate reflection of actual market prices for drugs.

Several companies publish the AWP of prescription drugs in printed and electronic databases. Drug manufacturers either provide information used to create AWPs, or report AWPs to the companies that publish AWPs. It is important to note that, although "AWP" is often referenced as a defined value, the values may differ by publisher. Most PBMs use Medi-Span and/or First DataBank as their source for AWP. Medi-Span's and First DataBank's AWPs do not differ from each other. RED BOOK is not commonly used by PBMs and during the study period of this report RED BOOK AWP differed from Medi-Span AWP. The difference between RED BOOK AWP and Medi-Span AWP is a result of the RED BOOK's AWP not being as comprehensive and not changing as frequently. We do not expect that this difference would have a material change on the review of estimated reimbursement levels, but this is something that should be considered by TDI-DWC if the definition of MAR is changed or updated.

While some PBM contracts base the reimbursement for generic drugs on a discount off AWP, many include a completely different structure, maximum allowable costs (MAC). Each PBM has its own MAC list(s), which may give the PBM sole discretion to define and change the maximum price it will pay for generic drug products. The MAC is used to negotiate lower drug prices for certain generic medications.

Typically, the discounts applied to AWP vary between brand name and generic drugs (with a greater discount for generic drugs), and retail and mail order drugs (with a greater discount on mail order). We have shown results separately for brand name and generic drugs, but have focused our comparisons only on retail reimbursement. Given the general inability of workers' compensation carriers to induce members through different levels of cost-sharing to use mail order pharmacies, we suspect that mail order is not common in the Texas workers' compensation arena. We have also shown all reimbursement levels before reductions due to rebates. Drug manufacturers commonly pay rebates as incentives to PBMs based on the volume of prescriptions relative to other therapeutic alternatives. Rebates are typically paid on brand name drugs only. While the impact of rebates will vary, in our experience they might represent an additional 2% to 6% reduction in overall drug ingredient costs in the commercial market.

The Texas workers' compensation pharmaceutical reimbursement is significantly greater than reimbursement in other healthcare markets, such as commercial group, Medicare and Medicaid. This is typical of workers' compensation programs in other states, based on our research. For example, according to a 2003 study by the National Council on Compensation Insurance (NCCI)[1], reimbursement equaled approximately 125% of AWP in workers' compensation compared to 72% in group health insurance. The majority of states define maximum allowable fee levels for workers' compensation pharmacy reimbursement, with the majority of those based on a percentage of AWP plus a dispensing fee. Studies completed by the Workers Compensation Research Institute (WCRI) indicate that the fee levels range from 88% to 140% of AWP, with most states setting the reimbursement level at AWP or a small percentage above AWP. This is dramatically different than other markets, where payments average below AWP levels.

Sources and Reimbursement Ranges

Discounts and dispensing fees for prescription drugs do not vary significantly by geographic location, or between HMO and PPO plans. They also do not vary significantly between the commercial and Medicare markets.

Table 3 below summarizes average reimbursement levels from a number of sources and types of programs. This section of the report also describes each of the sources in more detail and supplies additional detail from each, such as calculations from the source data, the range of reimbursement levels, and multiple years of data.

Table 3

Comparative Data from Other Markets – Average Retail Pharmacy Dispensing Fees and Reimbursement Levels Before Rebates

Market	Employer	Commercial	Medicare	Medicare	Medicaid Not Adjusted for MAC	Medicaid Adjusted for MAC – Estimated
Source/Year	PBMI* 2008	Milliman HCGs** 2008	Milliman Over 65 HCGs 2008	Milliman Part D Survey 2008	CMS Quarter Ending June 2009	CMS Quarter Ending June 2009
Brand Name						
Percentage of AWP	83.9%	85.0%	85.0%	84.8%	87.0%	87.0%
Dispensing Fees	$1.73	$1.80	$1.80	$2.02	$4.17	$4.17
Generic						
Percentage of AWP	58.2%	40.0%	40.0%	41.5%	83.8%	44.9%
Dispensing Fees	$1.79	$1.80	$1.80	$2.11	$4.40	$4.40

*Pharmacy Benefit Management Institute

**Health Cost Guidelines

[1] National Council on Compensation Insurance, Prescription Drugs: Comparison of Drug Costs and Patterns of Use in Workers Compensation and Group Health Plans Report, 2003

These results compare to the data provided by TDI-DWC and other states' workers' compensation program results, as follow in Table 4:

Table 4

Workers' Compensation Comparative Data

Basis	TDI-DWC Data	TDI-DWC Rules	Workers' Compensation Fee Schedules*
Source/Year	Results of Fee Analysis 2008	MAR Formula	WCRI As of 11/15/2005
Brand Name			
Percentage of AWP	96%	109%	101.8%
Dispensing Fees	$4.00	$4.00	$4.28
Generic			
Percentage of AWP	85%	125%	102.9%
Dispensing Fees	$4.00	$4.00	$4.64

*includes Texas

Note that the TDI-DWC results assume the $4.00 dispensing fee in the MAR formula, for comparative purposes.

Data Sources and Methodology

Milliman Health Cost Guidelines™ (HCGs): Milliman's HCGs are used by insurers, managed care organizations, and third-party administrators to estimate expected claim costs and model healthcare utilization. The HCGs are proprietary, used internally by Milliman's consultants and leased to insurers and other organizations.

The HCGs include typical pharmacy reimbursement levels based on public and private sources of data underlying our database, as well as default (expected) reimbursement levels, which are included in Table 3. While Milliman develops separate guidelines for commercial and over 65 populations, the expected discounts do not vary between them.

The HCGs are updated each year. For 2008, the range of pharmacy reimbursement for Retail was:

Table 5

Pharmacy Reimbursement Range of Observed Arrangements	
Retail	
Dispensing Fees	$1.50 to $2.25 ($1.80)
Percentage of AWP – Brand Name	83% to 87% (85%)
Percentage of AWP – Generic	See MAC reimbursement[1]
Maximum Allowable Cost (MAC) Generic Percentage of AWP	30% to 50% (40%)[2]
U&C Pricing	98% to 100% (99%)

[1] Negotiated reimbursement for generic drugs is typically determined under MAC pricing for retail pharmacies and on a discounted AWP basis for mail order pharmacies. In some cases, multi-source brand name drugs may be subject to MAC pricing instead of the more typical brand name discount.

[2] The generic discounts provided reflect the fact that MAC pricing does not apply to all retail generic drugs. Note: A restricted pharmacy network would generally produce discounts toward the higher end of the ranges above along with lower dispensing fees.

Default assumptions are in parentheses above. As noted earlier, we have focused our comparisons on retail reimbursement, prior to rebates. As a comparison, for mail order pharmacies, the default dispensing fees in the HCGs are $0.40 per prescription and the percentage reimbursement for brand name drugs is 78%. Generic drugs supplied through mail order pharmacies may or may not be based on MAC, but discounts are in similar ranges to retail arrangements.

Milliman Part D Survey: In each of the past three years, Milliman has compiled a summary of PBM arrangements for our Medicare Part D clients. We recently completed the 2010 version, which was based on Part D bids for 2010 compiled in 2009.

The results for 2008 were contained in Table 3. Following are the results for the three years of the survey:

Table 6

Milliman Part D Survey Results by Year

Market	Medicare	Medicare	Medicare
Source/Year	Milliman Part D Survey 2008	Milliman Part D Survey 2009	Milliman Part D Survey 2010
Brand			
Percentage of AWP	84.8%	83.0%	84.2%
Dispensing Fees	$2.02	$2.06	$1.96
Generic			
Percentage of AWP	41.5%	36.1%	32.2%
Dispensing Fees	$2.11	$2.16	$2.05
Number of Contributors	55	71	91

The above figures are averages for all contributors and include only retail reimbursement, before rebates. We note, based on the survey results, that there is significantly more variability surrounding the generic discounts than retail.

Discounts for generic drugs have increased considerably over the time of the surveys. Note that this result could be influenced by the mix of survey participants. The results indicate that larger organizations tend to have better contractual discounts than smaller organizations. In preparing the survey results, the Milliman authors relied on self-reported survey results from various Milliman consultants. This information was accepted without audit, but was reviewed for general reasonableness.

While the Part D discounts may not necessarily be representative of commercial discounts, some consultants within Milliman see the results as an indicator that commercial reimbursement is also going down, and that average reimbursement may be below the HCG results shown in Table 3.

PBMI: These results are from a report produced by the Pharmacy Benefit Management Institute (PBMI), "*Prescription Drug Benefit Cost and Plan Design Report, 2008-09 Edition.*" The results are based on an annual survey of employers and can be found at:

http://www.pbmi.com/2008_report/pdfs/Revised_Report_20112009.pdf

The report indicates that reimbursement levels have been declining over time, though more dramatically for mail order pharmacies than retail pharmacies. For 2007, the percentage of AWP paid for retail brand name drugs was 83.9% as in 2008, while it was 84.7% for the 2005-2006 study.

Because the results of this study are based on employer-reported data, we suspect that the generic discounts reported do not fully incorporate the impact of MAC pricing for generic drugs. According to the report, almost 87% of employers do use MAC pricing.

***CMS*:** Medicaid reimbursement by state is summarized on CMS's website; the current version is reproduced in Attachment 1 and can be found at

http://www.cms.hhs.gov/Reimbursement/Downloads/reimbursementchart2q2009.pdf

In order to calculate the average values shown in the comparative table, we used only the portion of the reimbursement formulas based on AWP. For example, if the reimbursement is "lower of WAC plus x% or AWP minus y%," we only used the percentage of AWP from the formula. We also made assumptions as to the most representative multiplier or calculated averages when reimbursement varied, for example, by independent and chain pharmacies. The first column of Medicaid values in Table 3 shows the average multipliers applied to AWP from the CMS display. In the second column, we assumed generic reimbursement is 40 percent of AWP if there is a state MAC. This is only an approximation, as this reimbursement level will vary by state depending on the MAC list. The vast majority of the states (45) have a state MAC.

WCRI: The workers' compensation reimbursement levels are based on a Workers Compensation Research Institute report "*The Cost and Use of Pharmaceuticals in Workers' Compensation: A Guide for Policymakers.*" The report includes state-by-state reimbursement levels that were in place as of November 2005. As with Medicaid, we only included those states whose formulas are based on AWP. This includes the majority of the states with defined reimbursement levels. Only two jurisdictions have MAC pricing based on the WCRI data; therefore, we did not adjust for the impact as we did with Medicaid.

This study can be purchased at http://www.wcrinet.org

Therapeutic Class Distribution

We reviewed the distribution of drugs and costs by therapeutic class in order to identify differences between Texas workers' compensation and commercial business. Following is a comparison:

Table 7

Therapeutic Class Distribution Comparison

	TDI-DWC Data 2008			Commercial Population Data*, U.S.		
Therapeutic Group Name	**% of Prescriptions**	**% of Payments**	**Rank (Prescriptions)**	**% of Prescriptions**	**% of Payments**	**Rank (Prescriptions)**
Analgesics/Antipyretics	49%	44%	1	10%	6%	2
Muscle Relaxants	13%	12%	2	2%	1%	18
Anxiolytic	6%	6%	3	4%	2%	7
Psychotherapeutic Agents	6%	7%	4	8%	11%	3
Anticonvulsants	4%	6%	5	2%	4%	14
Miscellaneous CNS Agents	3%	6%	6	1%	1%	24
Antibiotics	2%	1%	7	6%	3%	5
Antipruritics/Local Anest.	1%	4%	8	0%	0%	48
Adrenals & Comb.	1%	0%	9	2%	3%	13
Gastrointestinal Drugs	1%	2%	10	4%	9%	9
All Others	14%	11%		60%	60%	1
Totals						

*Based on Medstat HMO and PPO data for non-elderly adults, ages 18-64.

The Texas workers' compensation claims are heavily concentrated in a small number of drug classes as compared to commercial claims. The distribution of a Medicare population would show further differences. However,

because pharmacy reimbursement is generally based on a single discount percentage for brand name drugs, and discounts and MAC lists for generic, we consider both the commercial and Medicare reimbursement data to be useful comparisons to the workers' compensation fees. Nevertheless, it is possible that our results may be skewed by differences in the mix of drugs.

Market Share for Texas Workers' Compensation Compared to Other Healthcare Markets in Texas

The WCRI report referenced earlier indicates that workers' compensation prescriptions comprise less than 2% of prescriptions filled by major pharmacy chains nationwide. Based on National Health Expenditures data for 2006, workers' compensation prescription drug costs represented about 1.6% of all U.S. prescription drug costs. We estimate that the $133 million in drug claims reported in the 2008 TDI-DWC data may represent as little as 1% or less of the prescription drug payments in Texas. In reaching this conclusion, we estimated total pharmacy payments in Texas by market, including commercial, Medicare, Medicaid, and out-of-pocket by the uninsured based on Milliman's internal Healthcare Reform Database, a compilation of healthcare costs based on numerous published and unpublished sources.

DISCUSSION OF CHANGES IN AWP BY INSURERS AND HOW IT MAY IMPACT THE MAR

A recent court ruling requires First DataBank and Medi-Span to make special one-time modifications to their published Blue Book Average Wholesale Prices (AWP) after September 26, 2009. For all prescription drugs with a current AWP mark-up over the wholesale acquisition cost (WAC) in excess of 20%, First DataBank's and Medi-Span's published AWP will be reduced such that the AWP mark-up over the WAC is no greater than 20%. First DataBank and Medi-Span also agreed to cease the publication of Blue Book AWP within two years of the settlement.

Insurers and their contracted PBMs are taking different approaches to address this change. These approaches are described in detail in Attachment 2, a Milliman article entitled "The Impact of AWP Litigation on Your PBM Contract," and include revising the AWP discounts to be cost-neutral, revising AWP price points, or using alternate pricing terms such as WAC.

In defining a new MAR formula, it will be important for TDI-DWC to consider the issues associated with AWP and other benchmarks. Namely, if TDI-DWC continues with an AWP-based formula, the definition of AWP has become more ambiguous since September 26, 2009. In addition, AWP will not be published by First DataBank and Medi-Span within two years of the settlement date.

TDI-DWC has asked us to assist in providing guidance on the benchmark to be used to define future payment levels, given the uncertainty with AWP as a benchmark in the future. Ideally, TDI-DWC will adopt a fee guideline that will remain relevant over time and can be easily compared to fee levels in other systems, including government programs. Unfortunately, at this time it is difficult to predict what basis will most commonly be used as an alternative to AWP. Without further information, we would recommend moving to a guideline based on WAC; however, the environment may well change over the next few years so this issue should continue to be evaluated with the most current information available.

The WAC represents manufacturers' published catalog, or list, price for sales of a drug to wholesalers. WAC does not represent what wholesalers pay for drugs. WAC based pricing is used by the Department of Defense in the administration of its TRICARE prescription drug program, and it is used by at least six Medicaid programs as a basis for drug pricing. A WAC based pricing structure is more effective in the pricing of brand name drugs, and not as effective in the pricing of generic drugs. The competitive pricing of generic drugs is best based on a MAC, which is a managed list of maximum cost allowed for a generic drug product as set by a PBM or another party. It is possible for TDI-DWC to maintain its own MAC list for the purpose of a MAR for generic drugs, but the creation and ongoing management of a MAC list would lead to additional administrative work for TDI-DWC.

Based on the recent court ruling, TDI-DWC can use a factor of 1.20 to translate a desired post-settlement AWP-based fee guideline to WAC. For example, if TDI-DWC determines, based on the information in this report and other resources, that the fee guideline should be set at 90% of AWP, the equivalent percentage of WAC is 1.20 x 90% = 108% of WAC. Typically, in the commercial market, generic drugs will be paid at a discount from WAC or at a MAC, and brand name drugs will be reimbursed at or above WAC.

DATA RESOURCES

In developing our results, we have relied on data provided by TDI-DWC. This includes data files received on July 28, August 21, and August 27, 2009. The latest file included the following fields:

Field

- NCPDP or Pharmacy NPI
- Billing Provider FEIN
- Insurer FEIN
- Submitter FEIN
- DWC Claim Number
- Dispense as Written Code
- Pharmacy Line Date
- NDC Billed Code
- NDC Paid Code
- Drug Name
- Drugs/Supplies Qty Dispensed
- Drugs/Supplies Nbr of Days (Nbr of Days Billed)
- Drugs/Supplies Billed Amount
- Total Amount Paid
- Nbr of Days Paid (if missing assumed to be the same as Drugs/Supplies Nbr of Days)

First Service Adjustment

- Group Code
- Reason Code
- Amount
- Units

Second Service Adjustment

- Group Code
- Reason Code
- Amount
- Units
- Basis of Cost Determination Code

We also utilized the following external resources:

MediSpan Master Drug Data Base v2.5 (MDDB)

Published by Wolters Kluwer Health

Available for purchase at: http://www.medispan.com

MDDB provides the pricing and descriptive information on name brand name, generic, prescription and OTC drugs. MDDB is considered a industry leading comprehensive drug file.

Red Book Drug References

Published by Thomson Reuters

Available for purchase at: http://www.micromedex.com/products/redbook/

Red Book provides a significant amount of drug information, including contents to help identify, analyze and compare most drug products approved by the FDA.

Medstat

Published by Thomson Reuters

Available for purchase at: http://home.thomsonhealthcare.com

Medstat provides a significant amount of healthcare data including pharmacy claims experience.

CONCLUSION

This report summarizes current pharmaceutical reimbursement levels in the Texas workers' compensation system and compares them to levels paid in other markets. The results are intended to assist TDI-DWC in defining new fee guidelines for Texas.

We have not been asked to recommend specific reimbursement levels. However, we have been asked to assist in providing guidance on the benchmark to be used to define future payment levels, given the uncertainty with AWP as a benchmark in the future.

Ideally, TDI-DWC should adopt a fee guideline that will remain relevant over time and can be easily compared to fee levels in other systems, including government programs. Unfortunately, at this time it is difficult to predict what basis will most commonly be used as an alternative to AWP. Without further information, we would recommend moving to a guideline based on WAC, which will continue to be published after AWP is discontinued. However, the environment may well change over the next few years and TDI-DWC should further research and study the preferred baseline to be considered as part of the process to establish the future MAR.

GLOSSARY OF TERMS

Average Wholesale Price (AWP): A benchmark drug price level commonly used in pharmacy benefit plans. Pharmacy acquisition cost is typically lower than AWP.

AWP Discount: The negotiated discount off Average Wholesale Price (AWP) used to reimburse participating pharmacies.

Generic: A drug that has the same active ingredients, strength and dosage form of a brand name drug but is available at a lower cost. Generic drugs are only available after the patent protection on a brand name drug expires.

Dispensing Fee: The amount charged by a retail or mail pharmacy for the handling and dispensing of prescription medications.

Federal Upper Limit (FUL): Centers for Medicare and Medicaid Services (CMS) establish maximum prices that states may pay pharmacies as reimbursement for providing prescription drugs to Medicaid recipients. The FUL represents the maximum amount that Medicaid will reimburse pharmacies for certain multiple source drugs, and it is equal to 150 percent of the lowest priced version of the drug product.

Maximum Allowable Cost (MAC): A maximum fee schedule for generic drugs that encourages pharmacies to utilize less costly generic medications within a generic class. Reimbursement is limited to the lesser of the generic drug cost or the MAC price.

Pharmacy Benefit Manager (PBM): A company specializing in the administration and management of prescription drug benefit plans.

Rebates: Incentives paid by manufacturers to PBMs based on the volume of prescriptions relative to other therapeutic alternatives. Rebates are typically paid for formulary brand name drugs only.

Usual and Customary (U&C): Usual and customary pricing allows a plan to pay the pharmacy's cash price for a drug when that price is less than the drug's discounted price plus dispensing fee.

Wholesale Acquisition Cost (WAC): The price paid by a drug wholesaler to the wholesaler's supplier, typically the manufacturer. The WAC represents manufacturers' published catalog, or list, price for sales of a drug to wholesalers. WAC does not represent what wholesalers pay for drugs. WAC based pricing is used by the Department of Defense in the administration of is TRICARE prescription drug program, and it is used by at least six Medicaid programs as a basis for drug pricing. A WAC based pricing structure is more effective in the pricing of brand name drugs, and not as effective in the pricing of generic drugs. The pricing of generic drugs should be based on a Maximum allowable cost (MAC), which is a managed list of maximum cost allowed for a generic drug product as set by the PBM or another party.

ATTACHMENTS

Medicaid Prescription Reimbursement Information by State – Quarter Ending June 2009

ASP=average sale price, AWP=average wholesale price, WAC=wholesaler acquisition cost, NH=nursing home, FFS=fee for service SMAC=State maximum allowance cost and FUL=federal upper limit.
* Co-pay varies by cost of prescription.
** CMS Approved State Plans or State Source
Revised 07/09/2009

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
State of Alabama	Ingredient cost is lower of WAC plus 9.2% or AWP minus 10%	Dispensing fee is $5.40	Co-payment is $0.50 to $3.00 *	STATE MAC Yes
State of Alaska	Ingredient cost is AWP minus 5%	Dispensing fee is $3.45 to $11.46 (based on pharmacy/Medicaid volume)	Co-payment is $2.00	STATE MAC No
State of Arizona	Ingredient cost is AWP minus 15%	Dispensing fee is $2.00 (FFS only)	No co-payment	STATE MAC No
State of Arkansas	Ingredient cost is AWP minus 20% (generic); AWP minus 14% (brand)	Dispensing fee is $5.51	Co-payment is $0.50 to $3.00 *	STATE MAC Yes
State of California	Ingredient cost is AWP minus 17%	Dispensing fee is $7.25; $8.00 (legend drugs dispensed to residents in skilled nursing facilities or intermediate care facilities)	Co-payment is $1.00	STATE MAC Yes
State of Colorado	Ingredient cost is lower of AWP minus 35% (generic); AWP minus 13.5% (brand) Direct Price plus 18%; AWP minus 12% (rural)	Dispensing fee is $4.00 (retail pharmacy); $1.89 (institutional pharmacy)	Co-payment is $1.00 (generic); $3.00 (brand)	STATE MAC Yes

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
State of Connecticut	Ingredient cost is AWP minus 40% (selected multi-source brand and generic); AWP minus 14% (brand)	Dispensing fee is $3.15**	No co-payment	STATE MAC Yes
State of Delaware	Ingredient cost is AWP minus 14% (traditional, retail independent & retail chain pharmacies); AWP minus 16% (non-traditional, long term care & specialty pharmacies)	Dispensing fee is $3.65	No co-payment	STATE MAC Yes
District of Columbia	Ingredient cost is AWP minus 10%	Dispensing fee is $4.50	Co-payment is $1.00	STATE MAC No
State of Florida	Ingredient cost is lower of AWP minus 16.4% or WAC plus 4.75%	Dispensing fee is $4.23 (for non 340B billed drugs); $7.50 (340B billed drugs)	Co-payment for certain beneficiaries is 2.5% of payment up to $300, capped at 5% of total family income	STATE MAC YES
State of Georgia	Ingredient cost is AWP minus 11%	Dispensing fee is $4.63 (for profit pharmacy); $4.33 (not for profit)	Co-payment is $0.50 to $3.00	STATE MAC Yes
State of Hawaii	Ingredient cost is AWP minus 10.5%	Dispensing fee is $4.67	No co-payment	STATE MAC Yes
State of Idaho	Ingredient cost is AWP minus 12%	Dispensing fee is $4.94; $5.54 (unit dose)	No co-payment	STATE MAC Yes
State of Illinois	Ingredient cost is AWP minus 25% (generic); AWP minus 12% (brand)	Dispensing fee is $4.60 (generic); $3.40 (brand)	Co-payment is $3.00 (brand only)	STATE MAC Yes

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
State of Indiana	Ingredient cost is AWP minus 16% (brand); AWP minus 20% (generic)	Dispensing fee is $4.90	Co-payment is $3.00	STATE MAC Yes
State of Iowa	Ingredient cost is AWP minus 12%	Dispensing fee is $4.57	Co-payment is $1.00 (non-preferred brand) (no more than $25.00), $2.00 (non-preferred brand) (between $25.01 and $50.00), $3.00 (non-preferred brand) ($50.01 or more)	STATE MAC Yes
State of Kansas	Ingredient cost is AWP minus 27% (generic); AWP minus 13% (brand)	Dispensing fee is $3.40	Co-payment is $3.00	STATE MAC Yes
State of Kentucky	Ingredient cost is AWP minus 14% (generic); AWP minus 15% (brand)	Dispensing fee is $5.00 (generic); $4.50 (brand)	Co-payment is $1.00 (generic or atypical anti-psychotic); $2.00 (brand without generic equivalent); $3.00 (non-preferred brand); cap $225 per year per recipient	STATE MAC Yes
State of Louisiana	Ingredient cost is AWP minus 13.5% (independent pharmacies); (AWP minus 15% (chain pharmacies)	Dispensing fee is $5.77**	Co-payment is $0.50 to $3.00 *	STATE MAC Yes

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
State of Maine	Ingredient cost is AWP minus 15%; AWP minus 17% (on direct supply); AWP minus 20% (mail order)	Dispensing fee is $3.35; $1.00 (mail order); $4.35 and $5.35 (compounding); $12.50 (insulin syringe)	Co-payment is $3.00 (not to exceed $30 per month) No co-payments for mail order	STATE MAC Yes
State of Maryland	Ingredient cost is lower of AWP minus 12%, WAC plus 8%, direct price plus 8% or distributor price when available	Dispensing fee is $3.69 (generic); $2.69 (brand); $4.69 (generic to NH); $3.69 (brand to NH); $7.25 (home IV therapy)	Co-payment is $1.00 (generic and preferred brand); $3.00 (non-preferred brand)	STATE MAC Yes
State of Massachusetts	Ingredient cost is WAC plus 5% (all drugs except 340B billed drugs); actual acquisition cost (340B billed drugs)	Dispensing fee is $3.00 (all drugs except 340B billed drugs); $10 (340B billed drugs)	Co payment is $1.00 (multiple source and OTC); $3.00 (all other drugs)	STATE MAC Yes
State of Michigan	Ingredient cost is AWP minus 13.5% (independent pharmacy (1 to 4 stores); AWP minus 15.1% (chain pharmacies (5+ stores)	Dispensing fee is $2.50; $2.75 (long term care)	Co-payment is $1.00 (generic); $3.00 (brand)	STATE MAC Yes
State of Minnesota	Ingredient cost is AWP minus 12%	Dispensing fee is $3.65 (+$0.30 for legend unit dose drugs)	Co-payment is $1.00 (generic); $3.00 (brand)	STATE MAC Yes
State of Mississippi	Ingredient cost is lower of AWP minus 12% or WAC plus 9% (brand); AWP minus 25% (generic)	Dispensing fee is $3.91 (brand); $5.50 (generic)	Co-payment is $3.00 (medically needy only)	STATE MAC Yes
State of Missouri	Ingredient cost is lower of AWP minus 10.43% or WAC plus 10%	Dispensing fee is $4.09	Co-payment is $0.50 to $2.00 *	STATE MAC Yes

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
State of Montana	Ingredient cost is AWP minus 15%	Dispensing fee is $4.94; $12.50 to $22.50 (compounding)	Co-payment is $1.00	STATE MAC No
State of Nebraska	Ingredient cost is AWP minus 11%	Dispensing fee is $3.27 to $5.00 (based on service delivery, unit dosage or 3rd party payors)**	Co-payment is $2.00	STATE MAC Yes
State of Nevada	Ingredient cost is AWP minus 15%	Dispensing fee is $4.76; $22.40 daily (home IV therapy); $16.80 daily (nursing facility IV therapy)	No co-payment	STATE MAC No
State of New Hampshire	Ingredient cost is AWP minus 16%	Dispensing fee is $1.75	Co-payment is $1.00 (generic); $2.00 (brand & compound)	STATE MAC Yes
State of New Jersey	Ingredient cost is AWP minus 15%	Dispensing fee is $3.73 up to $3.99 (twenty-four hour emergency service and impact area location)**	No co-payment	STATE MAC Yes
State of New Mexico	Ingredient cost is lower of AWP minus 14%; wholesaler average cost as submitted to State; manufacturer price as submitted to State; pharmacy invoice price as obtained through audits.	Dispensing fee is $3.65	No co-payment **	STATE MAC Yes
State of New York	Ingredient cost is AWP minus 16.25% (brand); AWP minus 25% (generic); AWP minus 12% (specialized HIV pharmacies)	Dispensing fee is $4.50 (generic); $3.50 (brand)	Co-payment is $1.00 (generic); $3.00 (brand); $.50 (OTC)	STATE MAC Yes
State of North	Ingredient cost is AWP minus 10%, ASP	Dispensing fee is $5.60 (generic);	Co-payment is $1.00	STATE

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
Carolina	plus 6.7% (physician administered drugs)	$4.00 (brand)	(generic); $3.00 (brand)	MAC Yes
State of North Dakota	Ingredient cost is lower of AWP minus 10% or WAC plus 12.5%	Dispensing fee is $5.60 (generic); $4.60 (brand); plus $0.15 per pill (pill splitting)	Co-payment is $3.00 (brand)	STATE MAC Yes
State of Ohio	Ingredient cost is WAC plus 7% or if WAC cannot be determined, ingredient cost is AWP minus 14.4%	Dispensing fee is $3.70	Co-payment is $3.00 (non preferred drugs); $2.00 (preferred brand drugs)	STATE MAC Yes
State of Oklahoma	Ingredient cost is AWP minus 12%	Dispensing fee is $4.15	Co payment is $1.00 to $2.00 *	STATE MAC Yes
State of Oregon	Ingredient cost for multiple source drugs is AWP minus 15%; AWP minus 11% (institutional); AWP minus 68% (mail order); Ingredient cost for single source drugs is AWP minus 15%; AWP minus 11% (institutional); AWP minus 21% (mail order)	Dispensing fee is $3.50 (retail); $3.91 (institutional)	Co-payment is $1.00 (non preferred generic or generics costing $10.00); No co-payment (preferred generic & brand); $3.00 (all other brands)	STATE MAC Yes
State of Pennsylvania	Ingredient cost is lower of WAC plus 7% or AWP minus 14%	Dispensing fee is $4.00; $5.00 (compounding)	Co-payment is $1.00	STATE MAC Yes
State of Rhode	Ingredient cost is WAC	Dispensing fee is $3.40	No co-payment	STATE

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
Island		(outpatient), $2.85 (long term care)		MAC No
State of South Carolina	Ingredient cost is AWP minus 10%	Dispensing fee is $4.05 (independent pharmacy); $3.15 (institutional pharmacies)	Co-payment is $3.00	STATE MAC Yes
State of South Dakota	Ingredient cost is AWP minus 10.5%	Dispensing fee is $4.75; $5.55 (unit dose)	Co-payment is $3.00 (brand)	STATE MAC Yes
State of Tennessee	Ingredient cost is lower of AWP minus 16%, MAC or FUL for Pharmacy Benefit Management (PBM) National Network. Ingredient cost is lower of AWP minus 13%, MAC or FUL for TennCare Pharmacy Network. Special Pharmacy Rates are set separately	Dispensing fee for Pharmacy Benefit Management (PBM) National is $1.50 Dispensing fee for TennCare Pharmacy Network is $2.50 (brand); $3.00 (generic); $5.00 (brand nursing home) $6.00 (generic nursing home); $25 (compound prescriptions)	$0 (generics) and (Categorically Needy) $3.00 (Medically Needy)	STATE MAC Yes
State of Texas	Ingredient cost is lower of AWP minus 15% or WAC plus12%	Dispensing fee is $5.14 plus 1.95% of cost of drug	No co-payment **	STATE MAC Yes
State of Utah	Ingredient cost is AWP minus 15%	Dispensing fee is $3.90 (urban); $4.40 (rural)**	Co-payment is $3.00 **	STATE MAC Yes
State of Vermont	Ingredient cost is AWP minus 11.9%	Dispensing fee $4.75 (In-State) $3.65 (Out-of-State)	Co-payment is $1.00 to $3.00 *	STATE MAC Yes
State of	Ingredient cost is AWP minus 10.25%	Dispensing fee is $4.00; $5.00	Co-payment is $1.00	STATE

STATE	INGREDIENT COST	DISPENSING FEE	CO-PAYMENT	STATE MAC
Virginia		(unit dose drugs)		MAC Yes
State of Washington	Ingredient cost is AWP minus 14% (single source drugs); AWP minus 14% (multi-source drugs with four or fewer manufacturers/labelers); AWP minus 50% (multi-source drugs with five or more manufacturers/labelers and no MAC or FUL	Dispensing fee is $4.20 to $5.20 (based on 3-tiered pharmacy volume)	No co-payment	STATE MAC Yes
State of West Virginia	Ingredient cost is AWP minus 15% (brand); AWP minus 30% (generic)	Dispensing fee is $2.50 (brand); $5.30 (generic); $8.25 (340B billed drugs)	Co-payment is $0.50 to $3.00 *	STATE MAC Yes
State of Wisconsin	Ingredient cost is AWP minus 13%	Dispensing fee is $4.38; $0.015 per unit (for repackaging); $9.45 to $22.16 (compound drug fee); $9.45 to $40.11 (pharmaceutical care dispensing fee)	Co-payment is $0.50 (over-the-counter); $3.00 (brand); $1.00 (generic); cap $12 per pharmacy per recipient per month	STATE MAC Yes
State of Wyoming	Ingredient cost is AWP minus 11%	Dispensing fee is $5.00	Co-payment is $2.00	STATE MAC Yes

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Current Issues in Healthcare

The Impact of AWP Litigation on Your PBM Contract

By Brett Swanson , FSA, MAAA

A recent court ruling requires First DataBank and Medi-Span to make special one-time modifications to their published Blue Book Average Wholesale Prices (AWP). The change in AWP is scheduled to occur on Sept. 26, 2009. For all prescription drugs with a current AWP mark-up over the wholesale acquisition cost (WAC) in excess of 20%, First DataBank's and Medi-Span's published AWP will be reduced such that the AWP mark-up over the WAC is no greater than 20%. First DataBank and Medi-Span also agreed to cease the publication of Blue Book AWP within two years of the settlement.

Most pharmacy benefit managers (PBMs) intend on concurrently making adjustments to the contractual terms that determine ingredient costs such that, when First Databank's and Medi-Span's special adjustments occur and AWP values for drugs are reduced, the combined change to the contractual terms and AWP is cost-neutral to the PBM, the PBM's contract holders (customers), and the PBM's contracted pharmacies.

There are a number of approaches PBMs are taking to address the AWP litigation. Each approach has advantages and disadvantages. It is important for PBM contract holders to know the impact of each approach as they work with their PBM going forward.

Approach 1: Revised AWP Discounts

The first approach entails the PBM concurrently reducing the AWP discounts for brand and generic drugs in such a manner that when First DataBank's and Medi-Span's special adjustments occur and AWP prices for drugs are reduced, the combined change is cost-neutral to all parties overall. The goal of this approach is to determine the AWP discounts in such a way that, when applied to First DataBank's and Medi-Span's revised AWP prices, the impact to PBM contract holders (individually or collectively) will be cost-neutral when compared to the old discounted AWP and current contract holder discounts.

The impact of this change on a specific PBM contract holder may vary depending on its drug mix because the effect of this change is not uniform across all national drug codes (NDCs). Based on their size, smaller PBM clients will inherently have more variability as a result of this change. Figure 1 provides more detail regarding the potential AWP change based on a sample of contract holders for branded and specialty products.

Figure 1

Estimated Average Change in AWP by Contract Holder

Mean	Std. Dev.	Minimum	Maximum
-3.98%	0.02%	-4.02%	-3.96%

Some PBMs are using each contract holder's specific experience as a means to establish the cost-neutral discounts. This approach is operationally difficult for the PBM; however, because the change in AWP does not uniformly impact all drugs, using a contract holder's specific experience minimizes the opportunity for drug mix to affect the calculation of the equivalent AWP discounts.

Other PBMs are using block of business experience (average across multiple clients) as a means to establish the cost-neutral discounts. Because average adjustments are used, there could potentially be some *winners* and some *losers* through the adjustment process. However, some PBMs taking this approach are providing direct reimbursement (restitution) in order to offset the unfavorable discount adjustment (i.e., the *losers*), such that no contract holders are financially disadvantaged by the AWP adjustment.

Also, some PBMs are not adjusting the AWP discounts for generic drugs, which will benefit the vast majority of contract holders for a subset of generic drugs. However, the number of generic drugs that are affected by the change in AWP is minimal. Therefore, the benefit to the contract holder should also be minimal.

This approach also does not address First DataBank's and Medi-Span's agreement to cease publication of the Blue Book AWP within two years of the settlement date. PBMs taking this approach may need to go through another round of contract revisions with the PBM's customers and/or the PBM's contracted pharmacies to replace their AWP as this date draws nearer.

Approach 2: Revised AWP Price Points

A different approach involves the PBM concurrently adjusting the published AWP prices of each prescription drug based on historical WAC markup factors from First DataBank and Medi-Span. In other words, the adjusted AWP will be used to ensure that the markup over WAC is equivalent to the AWP markup over WAC before the reduction to the AWP.

This approach removes the potential for adverse variation across contract holders as the adjustments are made at the individual NDC level. Therefore, as drug mix changes over time and across contract holders, so does the degree of impact that is due to the First DataBank and Medi-Span settlement. However, this approach could be negatively perceived as it perpetuates the issue at the heart of the AWP litigation against First DataBank and Medi-Span. The PBMs may be in their right to make this adjustment; even if so, at a minimum, they will need to manage the perception of this approach.

One way to manage this perception is for PBMs to change the AWP publisher used as the basis to determine ingredient costs. Most PBMs currently use First DataBank or Medi-Span published Blue Book AWP as a pricing basis. However, because of the litigation, some PBMs may consider other publishers as a means to avoid changing AWP price points and/or the ceasing of publication of Blue Book AWP within two years of the settlement date altogether. Not all publishers of AWP are subject to the terms of the agreement to cease the publication of AWP within two years. For instance, Gold Standard is now going to publish multiple versions of AWP:

1. **Current Approach**–Calculated Average Wholesale Price (C-AWP), which is based on a markup of 25% applied to the reported WAC or direct price (DP).

2. **New Approach**–Calculated Average Wholesale Price 1.20 (C-AWP 1.20), which is based on a markup of 20% applied to the reported WAC or DP.

By publishing both AWP price points, Gold Standard leaves it up to the PBM (or other payer) to elect which version of AWP to use as a pricing basis.

Approach 3: Using Alternate Pricing Terms (i.e., WAC)

Another approach is where the PBM changes the pricing basis to be used in the determination of ingredient costs. For example, the PBM may change the terms with all contract holders to base the calculation of ingredient costs off of WAC plus a percentage, instead of a percentage off of AWP. This approach not only addresses the short-term issue of the determination of AWP changing effective Sept. 26, 2009, but it also addresses the issue of AWP no longer being published by First DataBank and Medi-Span within two years of the settlement date.

The operational burden for the PBM can be large under this approach as the contractual terms for each of their contract holders must be changed significantly. Not only must the PBMs develop a pricing system based on an entirely different approach to determining ingredient costs, but they also will be under competitive pressure to provide assurance that the revised terms are price-neutral to the contract holders. Using WAC, for example, this approach is complicated by the fact that not all NDCs have a published WAC price. Other alternatives to WAC could be average manufacturer price (AMP) or average sales price (ASP).

The use of AWP has been the standard pricing basis for most contract holders for a number of years. Changing to a new basis could be difficult as the contract holder may not have a good benchmark to compare contract terms (i.e., competitiveness of pricing discounts). Also, it will make the comparison of proposals obtained through the RFP process difficult as some are likely to be based on WAC (or some other non-AWP price point), while others will still be based on AWP.

Conclusion

It is important for PBM contract holders to understand which approach their PBMs plan to implement as a result of the settlement of the First DataBank and Medi-Span AWP litigation. Each PBM contract holder will want to ensure that the approach used by its PBM is transparent and indeed cost-neutral (or at least not adverse). Most PBMs have had independent parties validate the price neutrality of their methods. However, some approaches create potential *winners* and *losers*. It is also important to understand the approach of each PBM when undergoing an RFP process, contract renewal, or contract negotiations, as a direct comparison of pricing terms may no longer be a true *apples-to-apples* comparison.

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